REPORT TO THE
NOVA SCOTIA DEPARTMENT OF HEALTH

Annapolis Valley District Health Authority

Financial Review
May 30, 2002

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Executive Summary

Our Engagement

In February, 2002 the newly appointed CEO of District 3, Anne McGuire expressed to the Department of Health concerns that operating results and information provided to her, the Board and Department of Health might not be accurate. She based this concern on discussions with her staff.

After consultation between Ms. McGuire and staff of the Department of Health the Department (with Ms. McGuire's and the District 3 Board's concurrence) requested our services to determine whether information was being deliberately withheld or otherwise incorrectly reported. Specifically, we agreed to perform the following services:

1. **Review the processes with respect to budget preparation, approval and monitoring of actual results against the budget for the Year 2001 - 2002 and to the extent appropriate and practical compare to the processes previously in place for the Western Regional Health Board.**

2. **Provide an analysis and comfort with respect to the forecasted operating results for the year ended March 31, 2002 for the Annapolis Valley District Health Authority.**

3. **Review the management processes surrounding cash receipts and disbursements.**

4. **Provide comments and recommendations for improvements in processes resulting from our analysis.**

Budget Process

- Overall, there was a lack of ownership in the 2001 – 2002 budget process. Responsibility was allocated among several members of the finance group without adequate supervision or review. For example, finance staff gathered input and summarized budget information but were not involved in executive decisions. Therefore they were not able to understand initiatives and budget adjustments.

- The initial approach for budget preparation was appropriate. The finance group initiated the process by collecting information from the various operating units. That information was compiled, summarized, and reviewed by the finance group. Responsibility for the budget was transferred between Marguerite Rowe (former CEO) and the finance group while further changes were made prior to the presentation to the Board of Directors on September 6, 2001. The Department of Health (DOH) was informed of the projected shortfall on August 17, 2001. It appears that more significant difficulties in the process occurred from this point

on as numbers were adjusted several times and explanations for variances became more difficult to identify. The resignation of the CEO on August 15, 2001 most certainly contributed to these difficulties.

The lack of routine process and inadequate executive involvement appear to have been key factors in the confusion over budgeted results and its comparison to forecasted results.

- There was no senior financial officer in place to review the budget prior to its presentation to the Board of Directors and issuance to the Department of Health. Although other executives and the Board reviewed the document, without a senior financial review, controls over the budget process were weakened because the accounting staff were held responsible for both the preparation and the review of financial information. A further breakdown in the process occurred when the finance manager was excluded from the decision making process of the business plan and the budget, but was responsible for explaining discrepancies. The role of the finance managers appeared at times to include the responsibility of a CFO without the ability to make CFO decisions.

- Weaknesses in the budget monitoring process were also discovered. Because of the delays in providing financial results, the analysis of variances was often not timely. This was evidenced by the significant fluctuations in monthly forecasts as compared to other districts. Further, unit managers in the district were not provided with useful financial reports. More useful financial information provided to VP's and managers would create more accurate budgets and forecasts. Improved forecasting and reporting would enhance the ability to operate in accordance with a strategic plan.

Forecast

Draft audited financial statements as at March 31, 2002 indicate a deficit of approximately $1.2 million.

- In determining expected results for the year ended March 31, 2002, we discovered that results were not reported and reviewed in a timely manner. In some cases the reporting and analysis of monthly results occurred more than six weeks following the reporting date. Also, the monthly results did not reflect several large adjustments that occur only at year end, such as the adjustment for overtime. Improvements are required to the monthly financial statement close process to increase the timeliness and accuracy of financial reports.

Cash Disbursements and Receipts

- In our review of cash disbursements and receipts, it was determined that monthly bank reconciliations were not being prepared and reviewed in a timely manner. There were pieces of the total cash balance that had been reviewed by the finance group but a regular process did not appear to exist. This indicates a significant weakness over cash controls.

- Further, there was one bank reconciliation where a total of 10 bank accounts were consolidated and reconciled with outstanding cheques and deposits from all districts. This process makes reconciliation and review more difficult.

Observations and Recommendations

- We believe that based on the issues we have identified valid concerns were raised by the CEO of District 3 and the Department of Health. Further, the reporting and analysis provided to the Department of Health was inadequate and requires improvement.

- We have discovered no evidence of intentional misinformation by members of the finance group at District 3. We have however, concluded that the circumstances and issues raised above all contributed to the number of draft budgets prepared and the large variances between those budgets. Specifically, the organization was transformed from a region to districts with no overall leadership while the experience level of the individuals in place was not broad enough to implement changes and move forward with ongoing operations. The CEO at District 3 has committed to make improvements to the budget process for the upcoming year.

- Assuming shared services for finance continues for District 1, 2 and 3 one senior financial officer should be appointed to oversee the shared services group and be responsible for providing "CFO type services" to each of the districts. This position would create ownership over the budget process, control over monitoring of actual and budgeted results, and improve the process for overall financial reporting.

- Controls over cash should be immediately strengthened. Monthly bank account reconciliations should be completed and reviewed for each bank account in a timely manner. It is our understanding that the CEO of District 3 has already put into place procedures to deal with this issue.

Our Assignment

In February, 2002 the newly appointed CEO of District 3, Anne McGuire expressed to the Department of Health concerns that operating results and information provided to her, the Board and Department of Health might not be accurate. She based this concern on discussions with her staff.

After consultation between Ms. McGuire and staff of the Department of Health the Department (with Ms. McGuire's and the District 3 Board's concurrence) requested our services to determine whether information was being deliberately withheld or otherwise incorrectly reported. Specifically, we agreed to perform the following services:

1. **Review the processes with respect to budget preparation, approval and monitoring of actual results against the budget for the Year 2001 - 2002 and to the extent appropriate and practical compare to the processes previously in place for the Western Regional Health Board.**

2. **Provide an analysis and comfort with respect to the forecasted operating results for the year ended March 31, 2002 for the Annapolis Valley District Health Authority.**

3. **Review the management processes surrounding cash receipts and disbursements.**

4. **Provide comments and recommendations for improvements in processes resulting from our analysis.**

   Our procedures are summarized below. In subsequent sections we have discussed the results of our procedures.

   (i) We conducted an initial interview with Anne McGuire, CEO to gain an understanding of her concerns and to debrief her on our planned procedures and timeline.

   (ii) We had our Technology Security Risk Services staff take control of the computer memory drives of the three individuals who act as financial services managers in the shared services group for Districts 1, 2 and 3. As standard practice, these individuals had been temporarily relieved of their duties. This allowed the staff to return and continue to perform their normal functions while allowing us to have control of any information on the computers at the time of our appointment. This would prevent any alteration of information on the computers prior to the commencement of our assignment.

   (iii) We conducted an interview with Joe Haverstock, financial services manager assigned to District 1, to gain an understanding of the budget process for the Year 2001-2002. We understood Mr. Haverstock was the lead financial services

manager for budget preparation for all three districts.

(iv) We interviewed several staff within the Department of Health and the finance group at District 3. During these interviews, we collected information concerning the chronology of events within the budget process and reviewed the process to identify controls in place. Our understanding of the chronology of events is included as Appendix A. We verified the explanations provided to us by referring to written communications between the Department of Health and District 3 and also by reviewing budget documentation on file. We also tested controls identified in the process to the extent appropriate. During these interviews, we identified weaknesses in the process for which we have recommended improvements.

(v) We conducted a subsequent interview with Anne McGuire, CEO to discuss the District 3 business plan and reported budget as well as her expectations for March 31, 2002 results.

(vi) We requested the most recently completed year-to-date financial statements from the District 3 finance department. We were provided with February 2002 results. We analyzed the results and requested further detail for specific balances. We discussed balances with finance staff to assess their reasonability. Draft audited financial statements for the year ended March 31, 2002 were available prior to the issue of our report.

(vii) During our interviews and process reviews, we identified weaknesses in the processes for which we have recommended improvements. We also identified concerns and additional weaknesses in overall financial reporting. We have made recommendations for these concerns which we believe would contribute to a more effective finance department at District 3.

Budget Process

Budget Preparation

During March 2001, Joe Haverstock, Financial Services Manager, began the 2001-2002 budget process. There were four separate budgets prepared: Districts 1, 2, 3, and Shared Services. Shared Services were created during the 2001-2002 fiscal year as a result of the restructuring of the Western Region into 3 districts. They include: Finance, Materials, Information Technologies, Human Resources, Addiction Services, and Public Health.

All department managers were requested to submit information packages and budget forecasts for their respective departments by the first week in April, 2001. The finance department provided the managers with actual expense information for the period of March 31, 2000 to December 31, 2000. The general ledger printout had space provided for the managers to complete the estimated 2001/2002 amount.

The information packages received from managers included the most significant input to the budget which was payroll information for each staff member. The information detailed each staff members name, identification number and pay rate. The information also included the estimated payroll expenses using the general ledger printout, as mentioned above.

Budget binders contained all support for the budget and were organized by unit (e.g. nursing, surgery). Within each unit was a breakdown of each department. The back-up information behind each department indicated the expenses, and each department's payroll information was included. A comparison of each department to March actual results was also included as available.

All information packages from managers were received by the end of April 2001. Rick Boehner was hired on a contract basis to assist with the budget process until June 2001. Mr. Boehner was a former Director of Finance at South Shore Hospital. He reviewed the information submitted for reasonability and summarized all the information. Joe Haverstock, Financial Services Manager, remained the supervisor at this point. Any questions were formally returned to the managers for response.

Rick Boehner compared the first draft of the budget to the actual March 31, 2001 information, which became available by the time the budget was ready for submission.

The first draft of the budget did not include the net effect of the business plan initiatives. The largest expense at the hospital is payroll, and managers were instructed to use the "status quo" for their departments.

Budget Approval Process

Once Messrs. Haverstock and Boehner were satisfied with the first draft of the budget, it was presented to the CEO and the Chairman of the Board (not a normal procedure but he

was available) on August 1, 2001. The first draft of the budget was approved but with the intention of trying to find further ways to reduce the deficit. The deficit had grown from the business plan amount of $1.042 million to $2.645 million on the first draft. The first draft excluded orthopaedics funding.

After the first draft of the budget was approved, Marguerite Rowe (CEO until August 15, 2002) contacted some of the managers, to inquire if any additional cost savings could be implemented beyond the initiatives already included. Upon further analysis by the managers, an additional $300,000 was found, which was adjusted from the first draft of the budget, thus creating the second draft of the budget with a deficit of $2.305 million. Ernst & Young agreed this budget amount to a letter written to the DOH from Ms. Rowe prior to her resignation. She resigned on August 15, 2001 and Wanda Matthews, Financial Services Manager, was away on vacation from July 30 to August 13th. All cost savings incorporated into the second draft were completed under Ms. Rowe's supervision and were reviewed by Ms. Mathews upon her return on August 13th.

When Ms. Mathews returned from vacation it was discovered that some of the cost savings and business plan initiatives had been double counted. For example, cost savings related to diagnostic imaging film prices had been included twice. In addition, it was also discovered that some of the budget balances were incorrect as there had been some transposition errors that reduced the budget. Lastly, there were some additional unprojected expenses that were not reflected in the business plan or the budget, that were then incorporated into the budgets (consisted mainly of additional chemotherapy drug costs). These items were immediately adjusted in the budget.

Any duplicate savings were removed from the second draft of the budget, and the business plan initiatives were kept separate and intact. Cost savings and business plan initiatives are essentially the same thing, except the business plan initiatives were the original ideas and cost savings were new ideas discovered after the business plan had been submitted to the Province for review.

After these adjustments were made, a third draft budget was created with a net deficit of $1.772 million.

Within a letter dated August 17, 2002 Ms. Rowe informed the DOH of the deficit for District 3 for 2001/2002 of $1.772 million.

The third draft budget was entered in the accounting system at the end of August for the July month-end statements. The budget versus actual variances were calculated and presented on all month-end reports from that point on.

The third draft budget did not include the initiative affecting staffing levels, therefore the AVDHA felt it was appropriate to include the effect of those initiatives in the budget. The third draft budget then became the fourth draft budget as all the initiatives were added against the deficit netting to $853,000.

The final budget was presented to the board on September 6, 2001. The deficit was presented as $853,460. The budget was only presented at the meeting and not formally

approved in the minutes. This practice was consistent with the other 2 districts which formerly existed as the Western Region.

Access to change the budget is limited to 6 people but since the deficit number is known by all the finance department and the Board of Directors, any unauthorized changes would easily be discovered.

Budget Monitoring Process

Beginning in January 2002 for the month ended November 2001, each manager was asked to submit a variance report to the finance department, indicating the reasons for any discrepancy. In addition, managers were asked to comment if the expenditures in excess of budget were an error in the budget, or a non-recurring expenditure. No managers have the authority to increase their staff levels without permission from the CEO. However, managers have the ability to replace staff.

There are several hundred departments. Each manager can be responsible for up to 20 departments. There are three vice-presidents (Operations, Community Care, Patient Services). The vice-presidents report to the CEO and the CEO reports to the Board of Directors.

There are many departments because each site tracks its own costs, which are required submissions to the Canadian Institute of Health Information ("CIHI"). For example each location must track its own cleaning costs, even though the same staff member could be allocated to several locations. The AVDHA has five sites; Valley Regional Hospital, Eastern King Memorial Health Centre, Western King Memorial Health Centre, Soldiers Memorial, and Annapolis Community Health Centre. Mr. Haverstock informed us that no district can consolidate any of the departments and still comply with CIHI. However, departments can be consolidated for budget monitoring purposes using the report generator currently available.

Financial statements are required to be provided by the finance department to the managers, VP's, CEO, Board of Directors, Department of Health, and various Unions.

Weaknesses Identified within Budget Process

1. **No ownership over budget process**

   Responsibility for the budget was allocated among several people within the finance group. Without one individual overseeing the entire process, District 3 had difficulty completing an accurate budget and was not able to provide adequate analysis to the Department of Health. Prior to her resignation, Ms. Rowe appears to have had direct responsibility for the budget. With her departure, it appears no individual assumed or was given this responsibility until the appointment of Ms. McGuire in October.

2. **Inadequate review and approval of draft budget and supervision of finance group staff**

   Finance staff were responsible for producing the budget and were directed to make adjustments to the initial draft without fully understanding the initiatives causing the adjustments.

3. **Monitoring of budget to actual was weak**

   Not all unit managers submitted their variance analysis of budget to actual each month-end and those that were received were not timely.

   There was no recourse to the department or unit managers if budgets were not met. Performance evaluations in the previous Region have traditionally not considered the managers' ability to stay on budget. Without budget accountability for department or unit managers, the risk of unidentified errors in the budget and the risk of unidentified trends in actual results was high.

   Reports provided to the VP's consolidated their departments with other departments for which they were not responsible. More useful information could be provided to both the managers and VP's. For example if each manager's report consolidated only the departments within their control, the manager would have more useful information. Departments can be consolidated for budget monitoring purposes using the report generator currently available. If improved information were provided to managers for analysis, the budget variance analysis returned to the finance department could also be enhanced and overall, the monitoring of actual results to budget would be improved.

Cash Disbursements And Receipts

Our mandate included a review of the management processes surrounding cash receipts and disbursements. The following is a summary description of the systems from the initial purchase of materials and supplies through to payments and for invoicing and collection of accounts.

Materials Management (MM) Purchases and Invoicing

The materials management department ("MM") handles the majority of the hospital purchases, and is located in Lunenburg. The purchases process is initiated by purchase orders received from various departments via fax. The MM department then classifies the purchase order as either a stock item (item carried in inventory at the appropriate stores department) vs. non-stock item. All stock purchase requests are forwarded to the appropriate stores department. All non-stock purchase orders are forwarded to the purchasing office in Lunenburg.

The MM department agrees the authorization of purchase orders to a purchase approval listing. The purchase approval listing has not been updated since June 2000.

The MM department then enters the purchase order into their materials management system, which can be viewed by the finance group.

Receipt of Inventory

The various departments receive the ordered items and agree them to both the packing slip and the purchase order. The packing slips are then forwarded by the various departments to the finance group.

The invoices for all items ordered by Lunenburg are sent directly to the finance group. The finance group agrees all invoices to packing slips before any invoices are processed for payment. The items are then entered into payables for processing.

Payments

Some accounts payable do not follow the regular purchase approval and payment process. These invoices do not require a purchase order requisition in order to be received and subsequently paid.

The accounts payable accounting clerk is responsible for the selection and processing of accounts payable invoices for payment. Review and posting of the payment batch is conducted by the accounting supervisor. Once the batch is posted to the accounts payable system, a cheque is generated. The physical printing of the cheques is supervised by the general office clerk because the printer often does not work properly.

Before the cheques are printed however, either the Accounting Supervisor and/or the accounting clerk verify the cheque number with that indicated on the system. The printed cheques are then run through the cheque signing machine. This step of the process requires two keys, one that is held by the accounts payable clerk and one that is held by the accounting supervisor.

After the cheque run is complete, the accounting supervisor produces an "unused cheque list" report and provides the unused cheques to the general office clerk. The office clerk gathers all the unused cheques and attaches them to the report.

Cash Management

There is one bank reconciliation for bank accounts in all three districts. Upon further review it was discovered that the bank reconciliations are also several months behind. There are a total of 10 bank accounts, which are consolidated for purposes of reconciliation, and several of the accounts are inactive. District 3 is currently bringing their bank reconciliations up to date, and has plans to close any inactive bank accounts.

Request For Special Cheques (Manual Cheques)

Manually generated cheques are used primarily for payment on vendor accounts where payment has been delayed or for payroll errors.

The key control is the appropriate accounting supervisor's authorization. Accounts payable performs verifications of this authorization.

Cash Receipts

The Accounting Supervisor of Accounts Receivable and Financial Services Manager have complete access to the Accounts Receivable system. Accounting clerks and general office clerks have limited access to certain functions of the system.

When recording receipt of payment a payment type must be selected (cash, cheque, Visa, Mastercard, Interac or direct deposit). This is useful when doing deposits as the deposit summary from the system will list receipts by type to be balanced with actual deposit.

The receipt of cash is entered either against a receivable or a miscellaneous receipt. The daily receipts are balanced with the deposit summary. Depending on the site, deposits are either done daily, weekly, bi-weekly or monthly. A deposit summary is run to match the

deposit being sent to the bank. A copy is then forwarded to the Accounting Supervisor for verification when doing the bank reconciliation.

There is a "recipients file" which contains all patients, companies, or individuals who receive a service. Once a recipient is set up their recipient number cannot be changed or used by another recipient. Certain guidelines are also established to limit duplication of recipients. In addition, a "guarantor file" exists in the system containing names and addresses for parties other than the recipient who are paying for the service.

Within the Accounts Receivable system, users have read access only. Accounting supervisors and Financial Services Manager have access to add services or changes rates.

At the end of each week invoices are printed and sent out for all inpatient activities. If there are no charges the stay is not recorded in the AR system. An accrual activity file is keyed to include all patients still in the facilities at the end of the month. The system automatically posts and reverses this entry as part of the period end procedures.

Outpatient billing occurs as information is received from the various departments, either daily, weekly or monthly. These activities are keyed into the system and generally invoiced on a monthly basis.

Sundry billings arise from sale of inventory items to outside agencies, requests for copies of patient charts, salaries for Foundation staff etc. Sundry invoices are completed monthly by the accounting clerk. The ORMED Inventory Sales module has been implemented as of February, 2000. The invoice is sent with the goods and is generated from the system. To date this system is only being used from the Bridgewater inventory site.

Capital billings are done on a monthly basis. These are to Foundations / Auxiliary who have committed funds for capital equipment. Once a funded item is processed a copy of the invoice is obtained and billing is done. The capital process is currently performed by the accounting supervisor but will be transferred to an accounting clerk.
In the Aged Trial Balance electronic notes can be attached to any account. These can detail the difficulties or attempts to collect an account. If an account appears doubtful it can be tagged as such. Accounts with notes are then reviewed for potential write offs by the accounting supervisor. At some sites, accounts are sent to collection agencies after the 3rd statement which is accompanied with a letter. The letter outlines the District's intentions to send the account to collection if not paid within a prescribed time frame.

Staff are notified by the accounting supervisor of the closing date and time approximately one week in advance – approximately ten working days after month end. Once data is exported from Accounts Receivable and imported to the general ledger, reports are compared to make sure they are in balance.

On a monthly basis an aged trial balance by type, by facility is produced from the accounts receivable system. This is reconciled to the applicable account in the general ledger.

Weaknesses Identified with Cash Disbursements and Receipts Process

1. **Inadequate controls over cash**

   Bank reconciliations are not completed in a timely manner and the reconciliation process aggregates several bank accounts into one which makes identification of errors difficult.

2. **Control weakness within receipts of inventory**

   Receiving staff have the ability to edit a purchase order due to changes in the quantity ordered versus the quantity shipped. This increases the risk of unauthorized orders and/or payments. The purchase approval listing is also outdated.

Forecasted Results

As discussed later in our observations, we have concluded that results are not reported and reviewed in a timely manner. Strong controls over the budget and forecast are important to overall operations because inaccurate budget and forecast information could lead to inappropriate management decisions at both the District level and at the DOH.

The draft audited financial statements indicate a deficit at March 31, 2002 of approximately $1.2 million.

Observations and Recommendations

1. **Response to concerns as to whether information was being deliberately withheld or incorrectly reported.**

   Ms. McGuire met with DOH staff on February 27, 2002. At this meeting she reported a conversation she had the previous day with Wanda Mathews, the financial services manager for District 3 with respect to the apparent inconsistency with press reports of staff shortages and reports to DOH of unauthorized staff positions.

   Ms. McGuire reported that Ms. Mathews had expressed frustration and an understanding of Ms. McGuire`s frustration with financial information. She indicated that prior to Ms. McGuire`s appointment she had never been consulted prior to decisions being made and had often been told to ``make it happen`` within the 2001-2002 budget.

   She indicated that she and her co-financial services managers in Districts 1, 2 and 3 were very frustrated with the lack of overall control or direction in financial matters.

   In our view, the Board, Ms. McGuire and the Department of Health took appropriate steps in requesting a financial review. Ms. McGuire had been in place as CEO for little more than 3 months and had been unable to determine the financial position and forecasted results with any reasonable degree of accuracy or confidence.

   While our review did not indicate any evidence of intentional misinformation or the withholding of information requested or required, we did note a number of internal control and financial reporting deficiencies as outlined in this report.

2. **Budget Preparation and Approval Process**

   The approach for budget preparation initially appears appropriate. The requests for data, compilation and summary of budget information followed a clear process.

   Marguerite Rowe (former CEO) was the primary executive member involved in the process. Responsibility for the budget was unclear because several staff at the same level involved in certain aspects of the process with no one staff person responsible for the whole process. Further, she did not have a senior financial person on staff to oversee that executive level decisions were appropriately accounted for within the budget. In addition, a temporary staff person compiled and reviewed the budget information when a permanent full time staff member would have been more appropriate.

   The risk of misstatement and confusion within the budget was high considering the number of drafts completed, some of which were requested by the DOH, and the number of changes made without senior financial expertise involved. Further, there

appears to be a lack of control over the number of changes and drafts prepared. This is most likely due to the CEO position turnover and again the fact that several staff members were involved in the process at different levels, and as a result there was no one staff member who appeared to have ownership of the budget results as a whole.

3. Budget Monitoring Process

During our review of results presented to the Department of Health, it also became apparent that actual monthly results submitted by the District were much more volatile than those of other Districts in the province. This again caused the Department of Health obvious concern over the accuracy of financial reporting at District 3. Upon our review of the financial reporting processes, several factors were identified which would increase the risk of misstatement of monthly results and therefore cause unnecessary variances from month to month. They are summarized below:

- Although unit managers were requested to provide an analysis of variances from actual results compared to budget, not all managers were submitting their variance analysis each month-end and those that were received were not timely.

- Further, there was no recourse for the department or unit managers if budgets were not met. Performance evaluations traditionally have not considered the managers' ability to operate within budget.

- Reports provided to the VP's consolidates their departments with other departments for which they are not responsible. More useful information could be provided to both the managers and VP's. For example if each manager's report consolidated only the departments within their control, the manager would have more useful information. If improved information were provided to managers for analysis, the budget variance analysis returned to the finance department could also be enhanced.

4. Budget Monitoring Process

In preparing the upcoming 2002-2003 business plan, the Department of Health requested an analysis of the cost drivers used to prepare the business plan. These were to be additional costs only, as compared to prior year actual results. District 3 provided an analysis of cost drivers compared to prior year budgeted results.

The finance department at District 3 did not agree with the request made and did not understand the reasoning behind the comparisons requested. From our discussions with finance staff, they believed the comparison should have been "budget to budget" as opposed to "actual to budget". The finance group presented several different explanations of the cost driver variances to the Department of Health.

Ernst & Young reviewed the analysis provided by District 3 to the Department of Health and found, that without significant explanation, it would have been inadequate and confusing. Based on the documentation reviewed, we discussed the analysis with individuals at District 3. We discovered that explanation and support for the

variances existed but the presentation and number of changes was confusing and required excessive review and discussion to make sense of the explanations.

As analysis was being provided to the Department of Health and variances were being investigated internally, errors were corrected throughout the process of explanation. This accounts in part for the number of reports submitted as well as the confusion over changes to variances for no apparent valid reason.

Based on our review of the analysis as presented by District 3, it is understandable that the Department of Health would question the analysis provided.

5. Forecast

Draft audited financial statements for the year ended March 31, 2002 were available prior to the issue of our report. However prior to this in attempting to estimate results for the year ended March 31, 2002, we concluded that results are not reported and reviewed in a timely manner. Results as at February 28, 2002 were not completed and available until mid April, 2002. The timeliness of financial information is important if the information is to be useful to users and a delay of 6 weeks indicates that improvement is required in the financial statement close process. We were unable to determine a specific cause for the reporting delays. Rather, there were several areas identified where the process was weak and improvements are required.

Firstly, an effort should be made internally to challenge the reporting deadlines and review the processes to identify where efficiencies can be made. At a minimum, a schedule for month end tasks should exist based on reporting deadlines. Adjustments now only made at year-end should be re-assessed to determine whether monthly adjustments are worthwhile.

It also appeared that manual processes delayed the financial reports. For example, staffing requirements and unused vacation balances are manually prepared; these costs comprise a significant portion of the financial reports. With a computerized vacation accrual process, payroll information could be available on a regular basis, which would improve the efficiency of the financial statement close process.

Controls over the budget and forecast are important to overall operations because inaccurate budget and forecast information could lead to inappropriate management decisions at both the District level and at the DOH.

6. Cash Disbursements and Receipts

Most of the cash receipts and disbursements process had been well documented by the finance group at District 3. We reviewed their documentation and the processes and identified the following areas of concern.

Monthly bank reconciliations were not being prepared and reviewed in a timely manner. There were pieces of the total cash balance that had been reviewed by the finance group but a regular process does not appear to exist. This indicates a significant weakness over cash controls that should be immediately resolved. It is our

understanding that the CEO of District 3 has already put into place procedures to deal with this issue and that the reconciliation process is now well under way.

It was also identified that one bank reconciliation exists for all accounts in the districts. This approach makes reconciliation and review more difficult.

7. Key Recommendations and Conclusions

As a result of our analysis and conclusions discussed above, our key recommendations in relation to financial budgeting and reporting at District 3 are as follows:

1. Responsibility and ownership of the entire budget process should be assigned to one senior financial person who has the ability and position within the District to control the process, review reported budgets and monitor adjustments to draft reports.

2. An improved process should be implemented to involve unit managers in monitoring the variances between actual and budgeted results reported. This process should be managed by one senior financial person in the finance group.

3. The financial statement close process should be further investigated to determine reasonable reporting deadlines, to develop a workable closing schedule and to identify and resolve any delays or bottlenecks in the existing process.

4. Controls over cash should be immediately strengthened. Monthly bank account reconciliations should be completed and reviewed in a timely manner.

We have concluded that the concerns raised by the Department of Health are valid based on the information provided to them and based on the issues we have identified. It appears that the concerns raised were most likely a result of process deficiencies and unique circumstances during the budget process. The CEO at District 3 has committed to make improvements to the financial processes for the upcoming year.

We have discovered no evidence of intentional misinformation by members of the finance group at District 3.

Appendix A
Chronology of Events

Appendix A

As per our interviews with District 3 staff, the following summarizes our understanding as to the chronology of events surrounding the budget process.

January 1, 2001 – The three districts were separated. The AVDHA (District 3) was given a methodology "devolution" from the DOH, which stipulated the breakout of funding, and the separation of general ledger accounts. There was no prior budget for District 3 to rely on for 2001 as the prior year's budget had included all three districts.

January 25th, 2001 – All the CEO's of the new districts met with the DOH. The DOH provided all of the districts with 2001/2002 pressure budgets. Pressure budgets were created by the DOH using the 2000/2001 estimated operating expenses, and by adding an additional 2%. The DOH also provided the districts with their operating revenue for 2001. The estimated operating expenses exceeded the operating revenue provided by the DOH by $5.0 million. The CEO's were then asked to provide the DOH a "Business Plan" outlining the "initiatives" that the hospital would take to reduce spending by $5 million.

February 13, 2001 – The CEO took the pressure budgets back to managers to ensure that all estimated costs were included in the pressure budgets. District 3 felt that the pressure budget wasn't entirely accurate and changed the allocation of expenses; the net difference was a decrease of the deficit from $4.974 million to $4.929. The highlight of the reallocation was a reduction of the 2000/2001 deficit carry-forward and an increase in various expenses.

In addition to the revised pressure budget, AVHDA submitted their preliminary projected deficiency of $4.929 million less the preliminary initiatives and proposed initiatives. The preliminary incentives lowered the deficit to $3.686 million, and the AVHDA believed they should receive a reinstatement of one-time funding for non-closure of EHM/WKM, annualization of wage parity, and for the orthopedic program. If the previous one-time funding were provided by the DOH the deficit would be reduced to $1.2 million.

The proposed initiatives provided over $3.6 million in cost saving, but not all initiatives could be implemented.

February 21, 2001 – The initiatives were re-submitted to the DOH for review.

March 15, 2001 – The DOH, and District 1, District 2, and District 3 met where the DOH announced that additional funding would be provided. As per the DOH there would be no cuts to clinical, therefore the funding would be provided to clinical deficits, plus a percentage based on the hospital's efficiency.

March 30, 2001 – District 3 received the amount of revised funding that would be available for 2001/2002. The DOH also took this time to clarify that the net income must be zero.

May 15, 2001 – District 3 submitted their business plan to the province. The business plan includes revenues, expenditures, and the net effect of all initiatives that would be

implemented. The business plan projected a deficit for 2001/2002 of $300K, assuming the additional orthopedic funding of $742K would be received.

June 20, 2001 – DOH responded to the business plan dated May 15, 2001. The highlight's of the DOH response were as follows:

- The business plan was approved with the exception of the elimination of orthopedics program (AVDHA business plan included the option of the initiatives of orthepedics closing, as well as the funding from the Province), and the request for additional capital funding.

- The elimination of the orthopedics program as one of the incentives was disallowed because the DOH believed that the money received in the previous year for the orthopedics program was included in the base funding. However the AVDHA felt the money received to expand the orthopedics program didn't include the incremental costs to run the program in the current year, and proposed as one of the incentives to eliminate the program.

- The DOH recognized that the AVDHA plan was currently in a $1 million deficit situation, and requested a submission of a balanced budget by July 15, 2001.

- The DOH requested that the Alternative Level of Care policy (long-term care initiative) was to be effective July 1, 2001.

July 1, 2001 – AVDHA completed its first draft of the 2001/2002 budgets. Joe Haverstock, Financial Services Manager, prepared the budget. The budget projected a deficit greater than the deficit in the business plan. The budget was presented to the managers.

July 19, 2001 – AVDHA re-submitted the updated list of initiatives to the DOH. The updated initiatives were as listed in the business plan, and were reviewed for reasonability.

July 24, 2001 – AVDHA letter addressed to the DOH indicated a projected deficit of $1.772 million.

August 14, 2001 – DOH approved orthopedic program funding.

August 17, 2001 – AVDHA letter addressed to the DOH indicated a projected shortfall of $813K after the orthopedic funding was received. The projected deficit was comprised of the following:

- $158K – expenses that were unknown for the original business plan that became apparent after actual year-end numbers became available
- $257K – additional expenses included in the budget, but not in the business plan
- $200K – increase in actual chemotherapy drug cost.

- $157K – lost savings on delayed implementation of initiatives. The AVDHA cited the DOH delayed approval of business plan as the source.

September 12, 2001 – DOH letter responded to AVDHA letter dated August 17, 2001. The DOH stated that AVDHA must find a way to balance their 2001/2002 budget.

October 6, 2001 – AVDHA letter addressed to DOH requested additional funding from the DOH.

October 18, 2001 – DOH letter addressed to AVDHA refused request for additional funding, and instructed that the budget must balance. DOH stated that any deficit must be carried forward in the 2002/2003 business plan. The DOH requested an action plan be submitted to the province by October 31, 2001.

October, 2001 – DOH workshop held with the AVDHA to project 2002/2003 cost pressure budgets.

October 31, 2001 – The AVDHA did not submit an action plan to the DOH as requested, until December 7, 2001.

November 1, 2001 – AVDHA Board of Directors meeting minutes stated that the projected deficit at March 31, 2002 was now $1.7 million, and could be higher.

November 4, 2001 – AVDHA hired a consultant who met with the 5 largest over budget managers to revisit causes for overspending budget. In addition, the 5 managers with the most cost savings met with the consultant to encourage further cost savings.

November 14, 2001 – AVDHA submitted letter to the DOH.

November 23, 2002 – DOH approved up to $2 million carry forward of deficit for 2001/2002 to the 2002/2003 budget.

December 7, 2001 – AVDHA responded to DOH request for an action plan. The AVDHA reported a projected deficit of $1.9 million. The action plan proposed the closure of Annapolis CHC inpatients beds, Soldier Memorial transfer of all general surgery to Valley Regional, and Valley Regional discontinuation of "optional" subspecialties for a total cost reduction of $4 million. These closures would not be effective until the 2002/2003 fiscal year.

January 16, 2002 – AVDHA submitted their 2002/2003 business plan to the DOH.

January 30, 2002 – The AVDHA submitted letter to the DOH expressing their concern over information received about a 0% increase in funding. A re-submitted business plan was provided to the DOH.

February 1, 2002 – The DOH met with AVDHA to discuss the upcoming funding for 2002/2003. The projected deficit for 2002/2003 was $9 million provided that the DOH funding was consistent with 2001/2002 levels and that the 2001/2002 budgeted deficit was realized and not funded by DOH. Included in the upcoming deficit was $2.5 million

in additional funding for 28.46 FTE positions. As per Anne McGuire there were no new positions in the 2002/2003 budget. The current year deficit remained at $.853 million.

February 13, 2002 - The AVDHA revised their business plan again for 2002/2003.

February 20, 2002 – Onsite meeting between DOH staff and District 3 staff to review business plan and discuss deficit.

February 22, 2002 – The DOH received the revised Forecast. The current year deficit had grown to $1.96 million, and the 2002/2003 budget remained at a projected deficit of $9 million, but the additional funding for FTE of 28.46 had been reduced to 13.53 or $1.8 million.

February 25, 2002 – Meeting held between Ms. McGuire and Wanda Mathews with respect to apparent inconsistencies in reported financial information.

February 26, 2002 – Meeting held between Ms. McGuire, David Logey, District 3 Board Chair and DOH staff regarding Ms. McGuire's conversation with Wanda Mathews.

February 28, 2002 – Press release issued concerning financial review at District 3.

March 6, 2002 – Boyne Clark contacted AVDHA re: Wanda Mathews return to work.

March 13, 2002 – EY engagement letter to the DOH.